No. 16-2365

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Federal Trade Commission and
Commonwealth of Pennsylvania

Appellants,

v.

Penn State Hershey Medical Center and
PinnacleHealth System

Appellees.

On Appeal from the United States District Court
for the Middle District of Pennsylvania
No. 1:15-cv-2362 Hon. John E. Jones III

AMICUS CURIAE BRIEF OF THE ASSOCIATION OF INDEPENDENT DOCTORS

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Dated: June 8, 2016

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CORPORATE DISCLOSURE STATEMENT

The Association of Independent Doctors is a non-profit trade organization. It does not have a parent corporation or issue publicly traded securities.

INTRODUCTION & INTEREST OF THE AMICUS[*]

Penn State Hershey Medical Center ("Hershey") and Pinnacle Health Systems ("Pinnacle") insist that their merger would be in the best interest of patients in their geographic market because it will improve the quality and efficiency of care in the greater Harrisburg, Pennsylvania, area. The Association of Independent Doctors' broad experience, significant academic literature, and ample record evidence indicate otherwise.

If Hershey and Pinnacle were to merge, significant evidence exists to suggest that contrary to what the hospital systems argue, costs would increase, quality would decrease, and the patient community would suffer. The two hospital systems are the largest in the Harrisburg, Pennsylvania, area. Combined, they have 76% of the market according to the Federal Trade Commission. Their merger, should the court decide not to enjoin it, would create a sizable monopoly capable of significant increase in market power.

[*] No party or counsel for any party authored this brief in whole or in part or otherwise contributed monetarily towards its preparation or submission. No other person other than *amici*, their members, and their counsel contributed monetarily towards the preparation or submission of this brief. All parties have consented to the filing of this brief.

This merger would hurt patients, not only because they would pay higher prices for lower quality health care, but also because studies further show that when large health systems merge, patients have less choice and less voice. These adverse effects becoming more common as hospitals across American are merging with increasing frequency. Indeed, the rate of hospital mergers and acquisitions has more than doubled since 2009. In 2014, the United States saw a record-setting 100 mergers, up 14% from the prior year.

Wharton School, Univ. of Penn., *Hospital Consolidation: Can It Work This Time?* Knowledge@Wharton (May 11, 2015) (http://whr.tn/1H527oK).

As the New York Times recently reported, "[t]he rhetoric is all about efficiency," but "[t]he reality is all about higher prices." *See* Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. Times (Aug. 12, 2013) (http://bit.ly/1UjmqFB).

The Association of Independent Doctors ("AID") was founded in Winter Park, Florida, in 2013. A national nonprofit trade association that now has nearly 1,000 doctor members in 14 states coast to coast, AID was established to ensure that doctors, lawmakers, businesses, media, consumers and health advocates understand the negative impact that consolidation has on the cost of health care, patient choice, and the economy. These harmful ramifications occur not only when hospitals merge with other hospitals.

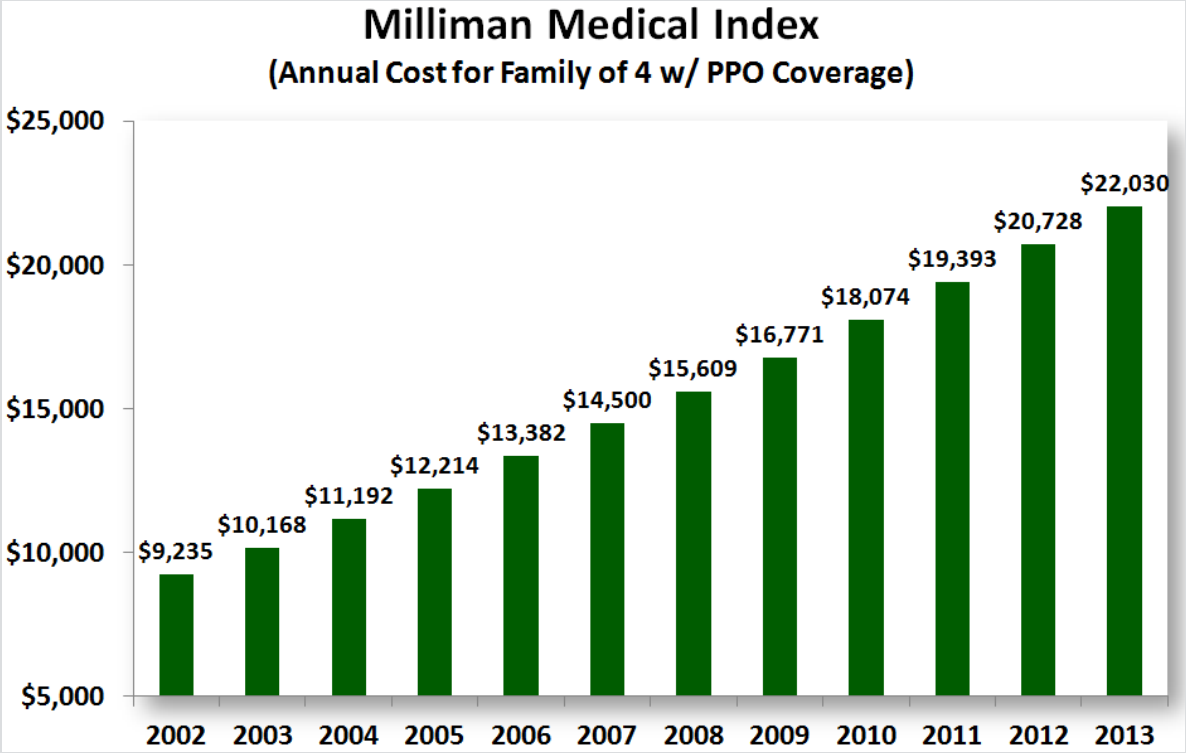
In the medical field, as in any other industry, competition is an important check against higher prices, diminished quality, and loss of consumer choice. The accelerating trend of increasing consolidation within the industry – whether hospitals and medical groups or hospitals with other hospitals -- is a leading driver behind rising health care costs.

Just as the number of independent hospitals is shrinking, the number of independent doctors as a percentage of total doctors has declined dramatically in recent years -- from 57% in 2000 to 36% in 2013. See Victoria Stagg Elliott, American Medical News (Nov. 19, 2012) (http://bit.ly/24morWC). During the same period, there has been a 55% surge in hospitals' employment of doctors. See Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* 33 (June 2013) (http://bit.ly/1U2egFt). Meanwhile hospitals have been amassing other hospitals. As a result, massive regional hospitals now have far greater market share, and far less competition, than they did just ten years ago.

This tectonic shift—the rapid decline of independent practices and commensurate rise of dominant hospital systems—has coincided with the doubling of health care costs over the last decade. Annual health care costs for an average family of four exceeded $22,000 per year in 2013. See Dan Munro, Annual Healthcare Costs for Family of 4 Now at $22,030, Forbes, (May 22, 2013).

http://www.forbes.com/sites/danmunro/2013/05/22/annual-healthcare-costs-surpasses-22000/#5dcc42de6963

For a fictional family of 4 (with a PPO) for each of the last 11 years looks like this:



Of the $22,030 health care cost for a family of four, the employer pays about $12,886 in employer subsidy while the employee pays the remaining $9,144, which is a combination of $5,544 in payroll deductions and $3,600 in employee out-of-pocket costs. For employees, this represents a cost increase of 6.5% over last year's total employee cost of $8,584.

Forbes, May 22, 2013.

It will come as no surprise that hospital consolidations have followed the same trajectory. Stemming these trends is vital to the future of Central Pennsylvania's health care system in particular, and the nation's health care system as a whole, AID's members have a strong interest in the proper resolution of this appeal.

STATEMENT OF CONSENT TO FILE *AMICUS* BRIEF

The Association of Independent Doctors' counsel secured the consent of Louis K. Fisher, Esquire, counsel to Appellees, to file this *Amicus* brief. The Association of Independent Doctors' counsel has authored this brief in whole and the Association of Independent Doctors has borne all expenses.

ARGUMENT

A. Large hospital systems provide lower quality and costlier care.

Were Hershey and Pinnacle to merge their already sizable health systems (Hershey's 551 beds plus Pinnacle's 662 beds), their combined bed count would total 1213 beds. The resulting conglomerate would become the 16th largest hospital in the country. *See* Dani Gordon, *100 largest hospitals in America,* Becker's Hospital Review (Aug. 7, 2014) http://www.beckershospitalreview.com/lists/8-7-14-100-largest-hospitals-in-america.html). This is out of more than 5600 registered hospitals in the United States, according the American Hospital Association.

The mergers would effectively eliminate the competition in the four county, general acute care service area. But the record evidence, academic literature, and AID's body of experience overwhelmingly demonstrate that competition among hospitals offers a number of very important benefits to both quality and cost for individual patients and the health system as a whole—benefits that are

undermined when hospitals merge to become one behemoth system monopolizing a market.

1. *The merger will lower the quality of care.*

a. Hospital mergers involving competing entities of this size harm quality of care because they limit physician choice—and, by extension, *patient* choice. Physicians who, prior to the merger, could refer to one of two neighboring health systems, now have are confined to one system. Most fundamentally, doctors are limited in their ability to refer patients outside the dominant hospital system because there are few choices, most of which are geographically inconvenient. That can only harm patients whose best interests are subordinated to the practical and geographic limitations.

When a large hospital system also employs the referring doctors, which is also a trend in consolidation, the situation worsens. "A term that some hospitals use to describe the referral of patients to providers and facilities outside their system is 'leakage,'" which represents "lost revenue." Richard Gunderman, *Should Doctors Work for Hospitals?* The Atlantic (May 27, 2014) (http://bit.ly/1sSdYX3).

It also is borne out by the academic literature. A recent study of health care mergers in New York found, for example, that one of the most pronounced effects of consolidation is that those merging lock up business

within target markets by controlling referrals and preventing leakage to competitors, which are now nonexistent. Robert S. Huckman, *Hospital Integration and Vertical Consolidation: An Analysis of Acquisitions in New York State*, 25 J. Health Econ. 77 (2005) (http://bit.ly/22Cy3xf).

In other words, "hospital consolidation[s] . . . do not simply reduce the number of firms providing substitute products"; rather, they also "alter the allocation of customers across firms with differentiated levels of quality and cost" by manipulating referral patterns. *Id*. And the impetus for this secondary effect is no mystery. By gaining "control of referrals," hospital systems "both get more patients and generate more revenue per patient." Gunderman, *supra*.

In short, as competition diminishes, it takes with it the opportunity for choice. The competitive edge is dulled when there is no competitor to keep it sharp. Specifically, the incentive to have a better heart program, or better cancer program, or better orthopedics program than a competitor goes away when the competitors become one.

There also is evidence that patients of smaller health care settings are better able to get appointments when they want them, better able to navigate through the departments, and benefit from the fact that "physicians, patients, and staff know each other better" in smaller settings. Lawrence P. Casalino et al., Small Primary Care Physician Practices Have *Low Rates Of Preventable Hospital*

Admissions, 33(9) Health Affairs 1, 6 (2014) (healthaffairs.org/content/early/2014/08/08/hlthaff.2014.0434.full.html). "[T]hese closer connections," also "result in fewer avoidable admissions." *Id*. These facts—which directly address the consumer welfare that is at the core of antitrust policy (*see Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979))—are well known and clearly established; Hershey and Pinnacle simply ignore them.

b. Against this backdrop, Hershey and Pinnacle are wrong to assert that no likelihood of anticompetitive effects would exist in any Harrisburg area services market. It is well settled that artificially limiting patient choice and diminishing the quality of care are forms of antitrust injury in their own right. As the Seventh Circuit has explained, it is an "anticompetitive effect" to limit, override, or otherwise "interfer[e] with consumers' free choice in choosing a product of their liking." *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 371 (7th Cir. 1990) (parenthetical omitted); and *Glen Holly Entertainment, Inc. v. Tektronix, Inc.*, 352 F.3d 367, 374 (9th Cir. 2003). Commentators agree. *See, e.g.*, Herbert Hovenkamp, *The Monopolization Offense*, 61 Ohio St. L.J. 1035, 1041 (2000) (it is an antitrust harm to "reduc[e] the array of choices that consumers would face under more competitive conditions") (http://bit.ly/1RT4Lme).

The basis for this rule is plain: conduct with no effect apart from eliminating

a consumer's ability to choose a rival's product is, by its definition, a foreclosure of competition. *Aspen Skiing Co. v. Aspen High- lands Skiing Corp.*, 472 U.S. 585, 605 (1985); *see also* Robert Bork, The Antitrust Paradox 138 (1978) (http://bit.ly/25ExpVd). That is just what this merger scheme would accomplish. Similarly, the "deterioration in quality of goods or services," standing alone, can be an "anticompetitive effect." *United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir. 1993). That, too, is the inevitable effect of the transaction challenged here. And that is an effect with human as well as economic costs, because the "deterioration in quality" is a deterioration in patient care and well-being.

2. *The merger will increase the cost of care.*

It would be bad enough if mergers by large hospitals simply reduced the quality of care and eliminated competition. But it is worse than that—it also increases the cost of care, often dramatically. And this case would be no exception.

a. Hospital spending is today "the largest category of health care costs, consuming nearly one-third of national health expenditures." Bob Kocher & Ezekiel J. Emanuel, *Overcoming the Pricing Power of Hospitals*, 308 J. Am. Med. Assoc. 1213, 1213 (2012) (http://bit.ly/1r5m11v) . In 2012 alone, Americans spent a staggering $880 *billion* on hospital-based care, exceeding the amounts spent on all of Social Security ($769 billion) and the national defense

($671 billion) during the same year. *Id*. Crucially, "hospital price increases are now the largest contributor to increases in insurance premiums." *Id*. Put simply, large hospital systems provide the costliest care possible. And if Hershey and Pinnacle form the nation's 16th largest hospital system, nothing indicates it will be an exception.

A principal explanation for such inflated hospital costs is that third party payers like Medicare and private insurers reimburse hospital systems at far higher rates than independent hospitals for otherwise identical services.

One academic study of 4.5 million patients compared costs of patients receiving treatment by a physician working within a free-standing hospital and one working within a multi-hospital system. The study found that patients receiving care within a multi-hospital system had mean per patient costs 10.7% higher than those receiving care within a hospital ($4776 mean cost compared to $4312). See James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, J. Am. Med. Assoc., 312(16) (2014) (http://bit.ly/1UjndWO). "The findings are not encouraging for proponents of integration...(and) are in contrast to the hope and expectation that organizational consolidation … would result in greater coordination, hence lower expenditures…. Antitrust law and policy need to find the appropriate balance between permitting hospital acquisitions that improve

efficiency, on the one hand, and preventing acquisitions that increase expenditures on the other." *Id*.

Other studies note the post-merger costs are higher: "[T]he recent wave of hospital consolidation has led to price increases for hospital care. A recent summary cites 8 studies that show price increases in the range of 10% to 40% due to mergers." David Cutler & Fiona Scott Morton, *Hospitals, Market Share and Consolidation*, J. Am. Med. Assoc. Vol. 310 No. 18 (Nov. 13, 2013) (http://bit.ly/1Y44vrB).

When Hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent. Martin Gaynor & R. Town, *The Impact of Hospital Consolidation*, Robert Wood Johnson Foundation, The Synthesis Project, (June 2012) (http://bit.ly/25BteWP).

Against this backdrop, several other recent econometric studies have addressed the relationship between price and hospital concentration in markets throughout the United States and found that "for the most part, hospital mergers in concentrated markets result in significant price increases." Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update* 2 (June 2012) (http://bit.ly/25BteWP).

All of this is well corroborated by the evidence before the district court.

The academic literature also consistently demonstrates that, a "large variation in the relative prices (exists) across markets" for the same services, precisely because there are "large differences in the bargaining clout of hospitals relative to health plans that allow some hospitals to negotiate much higher prices than others." *See* James D. Reschovsky & Chapin White, *Hospital Outpatient Prices Much Higher than Community Settings for Identical Services* 2 (June 2014) (http://bit.ly/1TSMXyZ). Reschovsky & White, 16 Nat'l Inst. for Health Care Reform at 5. *See also* Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs*, 33 Health Affairs 324 (2014).

Currently, Hershey and Pinnacle are direct competitors. Indeed, from the perspective of third party payers, each is the best alternative to a negotiated agreement with the other. But were they to become a single entity, their market power would increase while the ability for insurers such as Capital Blue Cross and Highmark to negotiate pricing would weaken – the hospitals' five-year agreement to hold current pricing notwithstanding. The very fact that the parties have such a contract with their primary third-party insurers implies that post-merger costs would rise and will rise.

Finally, the harm to competition still exists when a defendant uses market power in a primary market to "foreclos[e] rivals in [a] complementary

market even [when] the defendant sells the two products separately." Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 1757a (3d ed. 2007). *Cf.* Sze-jung Wu et al., *Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition*, 33 Health Affairs 1391 (2014) (http://bit.ly/1WBZPdf) (demonstrating that markets for ancillary services are competitive when patients are given choice and prices are transparent). And, regardless, the evidence demonstrates that, if merged, Hershey and Pinnacle would have more power to bill inflated rates for services, and that the leverage gained by the merger would give the new resulting monopoly the ability to make these higher rates 'stick' in future contract negotiations.

B. The speculative efficiencies identified by the defendants as following from the merger can be achieved by other means that do not hurt competition.

Hershey and Pinnacle assert that the merger would promote the procompetitive goal of integrated care and risk-based compensation. As other hospitals seeking permission to merge have insisted, the cost and quality of health care in the U.S. suffer from fragmented care. The "cure" for this troubling fragmentation is "integrated" care and risk-based pricing, which hospitals seeking consolidation say are possible only by creating massive health systems, which have the "technological infrastructure" to provide such advantages as

shared electronic medical records (EMR).

Hershey and Pinnacle are not the only hospitals asserting this position. And to justify these consolidations, the common refrain is that by consolidating, hospitals can achieve greater integration of care." *See also* Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?* 312 J. Am. Med. Assoc. 29, 29 (2014) (the argument "that merging of hospital systems can provide better care" typically relies on the assertion that "high-volume institutions . . . achieve more 'integrated' care").

But there are two notable problems with the claim that only "a larger health system" can achieve the "benefits of integrated care" and risk-based compensation. *First*, there is no basis—apart from Hershey and Pinnacle's bald assertions—for thinking that the merger actually would achieve either of those speculative goals. As demonstrated below, the academic literature, based on broad empirical experience, indicates that it would not. *Second*, the evidence—both in the record and more broadly—is crystal clear that, however the merger might encourage better coordination of care, those benefits may be achieved without consolidation and thus are not "merger-specific."

"[S]imply demonstrating that clinicians and health care provider entities have increased access to a common EMR in a large system, for example, will not outweigh the harm from higher prices." See Cutler & Morton, *supra.* There are

other ways to share EMR without merging.

1. There is no evidence that the merger will promote integration of health care at all.

a. No credible evidence—on this record or anywhere else—demonstrates that merging large hospitals actually promotes integrated care or any other procompetitive efficiencies.

That finding is consistent with earlier studies explaining that, because "economic integration is not designed primarily to promote clinical integration," the evidence points to a "lack of [any] relationship" between the two. Lawton Robert Burns & Ralph W. Muller, *Hospital-physician collaboration: landscape of economic integration and impact on clinical integration*, 86 Milbank Q. 375, 404 (2008) (http://bit.ly/1XVTNmW); *see also, e.g.*, Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 J. Health Econ. 1 (2006) (similar) (http://bit.ly/1X2yq4k). A separate report published in 2012 concluded that, while consolidation has "the *potential* . . . for creating integration," recent "research evidence" indicates that "consolidation d[oes] *not* lead to true integration," and that "[c]onsolidation is often motivated," instead, "by a desire to enhance bargaining power by reducing competition." Gaynor, *The impact of hospital consolidation*, at 4-5 (emphasis added; other emphasis omitted) (http://bit.ly/25BteWP) . Just so here.

These studies confirm what common sense suggests: mergers like the one

at issue are driven by the lure of increased profit, not coordination of care.

"Not only are merged hospitals struggling to reap efficiency gains, (but) they're also failing to pass along any benefits of size to their end customers – the patients…The preponderance of the evidence is that consumers lose. They lose because prices rise, and that gets translated into higher premiums." Wharton School, *supra*

2. The purported benefits of the merger are speculative and not merger-specific.

Even if there were evidence that meaningful clinical integration or other procompetitive efficiencies might result from the merger, no evidence suggests that any such benefits would be merger-specific.

a. The legal framework is familiar. An antitrust defendant may rebut evidence of a prima facie violation of the Sherman and Clayton Acts by showing that the challenged transaction would produce "'significant' or 'extraordinary' efficiencies" to offset the harm to competition. Areeda & Hovenkamp, *supra*, ¶ 976d. It is established, however, that "the asserted efficiencies must be 'merger-specific' to be cognizable as a defense." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721 (D.C. Cir. 2001); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 572 (6th Cir. 2014) (efficiencies must "result from th[e] merger" itself, and not from independent initiatives by "the merging parties"). "An efficiency is said to be 'merger specific' if it is a unique

consequence of the merger—that is, if it could not readily be attained by other means or if the social cost of attaining it by other means is at least as high as the social cost of the merger." Areeda & Hovenkamp, *supra*, ¶ 973a; *see also* U.S. Dep't of Justice & FTC, *Horizontal Merger Guidelines* § 10 (2010) (hereinafter "*Guidelines*") (http://bit.ly/1RT4KyC) (an efficiency is "merger-specific" when it is "likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of [it]"). Efficiencies are not "merger-specific if they could be attained by practical alternatives that mitigate competitive concerns." *Guidelines* § 10 n.13.

Here, there is no doubt that "practical alternatives" to the merger are available to achieve integration of care. "Clinical integration requires meaningful data sharing, systems for effective hand-offs [of patients], and streamlined care transitions," which "can be achieved through other mechanisms" than mergers of hospital systems. Tsai, 312 J. Am. Med. Assoc. at 29.

One alternative approach for achieving clinical integration, for example, is "participating in health information exchanges." Tsai, 312 J. Am. Med. Assoc. at 29. Such exchanges provide seamless, electronic transfer of clinical information among different health care information systems. Crucially, "there has been a rapid increase in the availability of health information exchanges across the nation and many hospitals are now participating in these arrangements."

Id. But, ironically, "[l]arger systems may be less motivated to join health information exchanges" because "information is seen as a tool to retain patients within their system, not as a tool to improve care." *Id*.; *see also* Amalia Miller & Catherine Tucker, *Health Information Exchange, System Size and Information Silos*, 33 J. Health Econ. 28 (2014) (http://bit.ly/1Y6tr1Z). In this way, "hospital mergers may create new islands of data" that *hinder* rather than promote integration. Tsai, 312 J. Am. Med. Assoc. at 29.

Accordingly, the transaction of the Hershey and Pinnacle merger is simply not necessary to provide integrated patient care.

While the Court's decision on this matter could have profound implications for health care in the United States, and will potentially set a precedent for future mergers, a decision to enjoin this merger does not constrain procompetitive consolidations, but reaches only anticompetitive consolidations. Most obviously, if a future merger does *not* have market power—that is, if the merging hospitals could not impair competition once combined—no antitrust concerns would arise, and the transaction should be allowed to proceed.

Moreover, simply because Hershey and Pinnacle identify what they believe could be possible benefits of the transaction, they should not assume the burden shifts back to the government to prove that the benefits were not merger-specific. That is not the law. As the D.C. Circuit has recognized, "the asserted efficiencies

must be 'merger-specific' to be cognizable as a defense." *Heinz*, 246 F.3d at 721. *See also* Areeda & Hovenkamp, *supra*, ¶ 973a ("the efficiency defense requires a showing that claimed efficiencies are 'merger specific'"). And because "it is incumbent upon the merging firms to substantiate efficiency claims" (*Guidelines* § 10), Hershey and Pinnacle bear the burden of demonstrating, from the outset, that the merger would have not just procompetitive benefits, but *merger-specific* procompetitive benefits.

Hershey and Pinnacle have not come close to making that showing in this case. Any claims about improved quality are speculative. Without evidence of merger-specificity, the asserted benefits do not weigh in the balance at all. And so it is here.

Now comes the question of the role of the court in the future of American health care. In his decision, U.S. District Court Judge John E. Jones III wrote that his opinion recognized a need to adapt to "an evolving landscape of health care that includes, among other changes, the institution of the Affordable Care Act ("ACA"), fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting."

Judge Jones wrote, "Our determination reflects the health care world as it is, and not as the FTC wishes it to be. We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually

compels institutions to seek alliances such as the hospitals intended here."

There are two problems with this analysis. First, overlooked in that assessment is that while, yes, the ACA creates incentives for hospitals and physicians to create Accountable Care Organizations[†] (ACOs), an important and often forgotten prerequisite for this model is hospital competition. Marty Makary, *The Obamacare Effect: Hospital Monopolies*, The Wall Street Journal, (April 19, 2015) (http://bit.ly/1srGeQB).

Second, is the question of reach. In *Saint Alphonsus Medical Center-Nampa Inc v. St. Luke's Health System, LTD,* 778 F.3d 775 (9th Cir. 2015), the Appeals Court for the Ninth Circuit upheld the Idaho district court's decision to unwind a merger between a hospital and a large medical group. In doing so, it reasoned: "As the district court recognized, the job before us is not to determine the optimal future shape of the country's health care system, but instead to determine whether this particular merger violates the Clayton Act." *Id*. at 781.

C. Competition, not consolidation, will better ensure efficiency and quality.

One final observation follows inescapably: contrary to Hershey and

[†] Accountable care organizations, or ACOs "are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their . . . patients." Centers for Medicare & Medicaid Services, *Accountable Care Organizations (ACO)* (archived at perma.cc/QG7N-EQWL). Although "[p]articipating in an ACO is purely voluntary for providers" (*id*.), the Affordable Care Act encourages health care providers to participate through the Medicare Shared Savings program. *See* Patient Protection and Affordable Care Act § 3022, Pub. L. No. 111-148, 124 Stat. 119, 395-399 (2010) (codified at 42 U.S.C.1395jjj) (http://bit.ly/1t6eRMs).

Pinnacle's unsupported assertions, competition, not consolidation, better ensures efficiency and quality in the delivery of health care services.

"Moving from [a model of] hospitals [as] price setters to a market in which patient demand drives hospital prices and quality improvement" necessarily requires "systems that [concentrate on] outcomes as opposed to activity, [and that] are focused on service and quality" as opposed to volume. Kocher & Emanuel, 308 J. Am. Med. Assoc. at 1214 (http://bit.ly/1r5m11v). Recent literature concerning the effects of competition on health care quality and cost repeatedly has shown that "both mortality and expenditures are lower in less concentrated markets" that are sensitive to competition. Martin Gaynor et al., *The Industrial Organization of Health Care Markets* 13 (Jan. 7, 2014) (http://bit.ly/1UAJWQV) . Put another way, "introduction of competition l[eads] to an increase in quality without a commensurate increase in expenditure." Martin Gaynor et al., *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Services* 4, National Bureau of Economic Research Working Paper 16164 (2010) (http://www.aid-us.org/resources/Documents/Gaynor%20Death%20by%20Market%20Power.pdf). These results suggest that competition is an important mechanism for enhancing the quality of care patients receive "without chang[ing the] total expenditure or increas[ing the] expenditure per patient." *Id*. at 31-32. Thus, while consolidation may help hospitals' bottom lines, competition is what helps patients.

Simply put, "hospital competition save[s] lives." Zack Cooper, et al., *Does Hospital Competition Save Lives? Evidence from the English National Health System Patient Choice Reforms*, 121 Econ. J. F228, F251 (2011) (http://bit.ly/288xT4I). AID's experience supports the same conclusion: when hospital systems merge and dominate a market, inevitably costs rise, quality falls, and patients bear the brunt. That is not a result the antitrust laws should countenance.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision below and enjoin the proposed merger between Hershey and Pinnacle pending the outcome of the administrative adjudication.

Respectfully submitted,

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Dated: June 8, 2016

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CERTIFICATE OF COUNSEL

The undersigned counsel hereby certifies that:

1. I am a member of the Bar of this Court.

2. The text of the electronic version of this Brief is identical to the text of the paper copies.

3. The following virus detection program – Norton 360 Premier by Symantec, Version 22.6.0.142 – was run on the file and no virus was detected.

4. This brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because this brief contains 4,656 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

5. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word 2010 and in 14 point Times New Roman font.

/s/ Charles I. Artz
Counsel of record for *Amicus Curiae*

Dated: June 8, 2016

CERTIFICATE OF SERVICE

I certify that on June 8, 2016, I filed the foregoing *Amicus Curiae* Brief for the Association of Independent Doctors via the Court's electronic filing system. All parties have consented to receive electronic service and will be served by the ECF system.

/s/ Charles I. Artz

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